TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Great American Assurance Company

MFDR Tracking Number
M4-15-2833-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Office visits are recommended as determined to be medically necessary. Medical necessity for office visits in conjunction with work status forms 73."

Amount in Dispute: $254.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 12, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2014 & December 9, 2014	Evaluation & Management, established patient (99213) Work Status Report (99080-73)	$254.66	$127.33

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the general provisions for dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §129.5 sets out the procedures for Work Status Reports.

4. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
5. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
6. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
7. 28 Texas Administrative Code §134.600 defines services that require preauthorization.
8. 28 Texas Administrative Code §137.100 sets out the procedures regarding treatment guidelines.
9. 28 Texas Administrative Code §141.1 sets out the procedures for requesting a Benefit Review Conference.
10. 28 Texas Administrative Code §19.2003 provides definitions for terms related to utilization reviews.
11. 28 Texas Administrative Code §19.2009 sets out the procedures for notices of determination of utilization reviews.
12. 28 Texas Administrative Code §19.2010 provides the requirements prior to issuing adverse determinations of utilization review.
13. Texas Labor Code §410 defines the process for adjudication of disputes.
14. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

    <u>For date of service November 25, 2014</u>:

    - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
    - 270 – No allowance has been recommended for this procedure/service/supply. Please see *note* below.
        - *Note: "270 – NO PAYMENT IS BEING MADE, THE CLAIM HAS BEEN DENIED BY ADJUSTER."
    - P12 – Workers' Compensation jurisdictional fee schedule adjustment.

    <u>For date of service December 9, 2014</u>:

    - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
    - 270 – No allowance has been recommended for this procedure/service/supply. Please see *note* below.
        - *Note: "**PLS DENY**DO NOT ALLOW ANY PYMT PER PEER REVIEW, CHIRO TX IS OUTSIDE ODG."
    - B84 – Services not authorized.
    - 270 – No allowance has been recommended for this procedure/service/supply. Please see *note* below.
        - *Note: "RE-EVALUATION: THIS SERVICE WAS DENIED PER PEER REVIEW AND CLIENT'S INSTRUCTIONS. THEREFORE, WE ARE UNABLE TO RECOMMEND ANY ALLOWANCE AT THIS TIME."
    - 97 – The benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated.
    - 284 – No allowance was recommended as this procedure has a Medicare status of 'B' (bundled).

<u>Issues</u>

1. Is date of service November 25, 2014 eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.305?
2. Does CPT code 99213, date of service December 9, 2014, require preauthorization?
3. Are the insurance carrier's reasons for denial of payment for date of service December 9, 2014, CPT code 99213, supported?
4. Are the insurance carrier's reasons for denial of payment for date of service December 9, 2014, CPT code 99080-73, supported?
5. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
6. Is the requestor entitled to additional reimbursement?

<u>Findings</u>

1. This medical fee dispute for date of service November 25, 2014 contains unresolved issues of extent-of-injury for the same services for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical billing process.

    - **Dispute resolution sequence:** 28 Texas Administrative Code §133.305 (b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307 (f)(3)(C) provides for dismissal of a medical fee dispute if the request for

the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307 (c)(2)(K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

- **Extent-of-injury dispute process:** The Division hereby notifies Elite Healthcare Fort Worth that the appropriate process to resolve the issues of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to Elite Healthcare Fort Worth, instructions on how to file for resolution of the extent of injury issue are attached.

2. The insurance carrier denied date of service December 9, 2014, CPT code 99213, in part, with claim adjustment reason code B84 – "SERVICES NOT AUTHORIZED." 28 Texas Administrative Code §134.600 (p) and (q) define services that require preauthorization or concurrent review. CPT code 99213 does not meet the requirements found in this rule. Therefore, this service does not require preauthorization. The insurance carrier's denial for this reason is not supported.

3. The insurance carrier denied date of service December 9, 2014, CPT code 99213 and CPT code 99080-73, in part, with claim adjustment reason code 270 – "No allowance has been recommended for this procedure/service/supply. Please see *note* below." The carrier used the following notes to clarify this denial:

   - "**PLS DENY**DO NOT ALLOW ANY PYMT PER PEER REVIEW, CHIRO TX IS OUTSIDE ODG."
   - "RE-EVALUATION: THIS SERVICE WAS DENIED PER PEER REVIEW AND CLIENT'S INSTRUCTIONS. THEREFORE, WE ARE UNABLE TO RECOMMEND ANY ALLOWANCE AT THIS TIME."

   28 Texas Administrative Code §137.100 (e) states,

   > An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

   Retrospective utilization review is defined in 28 Texas Administrative Code §19.2003 (b)(31) as,

   > A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

   In addition, 28 Texas Administrative Code §133.240 (q) states, in relevant part,

   > When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ...

   Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). The insurance carrier's denial for this reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

4. The insurance carrier denied date of service December 9, 2014, CPT code 99080-73, in part, with claim adjustment codes 97 – "THE BENEFIT FOR THIS SERVICE IS INLCUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED," and 284 – "NO ALLOWANCE WAS RECOMMENDED AS THIS PROCEDURE HAS A MEDICARE STATUS OF 'B' (BUNDLED)."

   28 Texas Administrative Code §134.204 (a)(5) states, in part,

Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

28 Texas Administrative Code §134.204 (l) states,

The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).

28 Texas Administrative Code §129.5 sets out the procedures for Work Status Reports, including reimbursements. Therefore, Medicare bundling rules do not apply to this service. The insurance carrier's denial for this reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

5. Reimbursement for CPT code 99213 on December 9, 2014 is subject to the fee guidelines in 28 Texas Administrative Code §134.203. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2014 is $55.75.

   For CPT Code 99213 on December 9, 2014, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 0.971940. The practice expense (PE) RVU of 1.00 multiplied by the PE GPCI of 0.987 is 0.987000. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.799 is 0.055930. The sum of 2.014870 is multiplied by the Division conversion factor of $55.75 for a MAR of $112.33.

   28 Texas Administrative Code §129.5 (i) states, in relevant part,

   Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15 … (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section…

   Therefore, the MAR for CPT code 99080-73 on December 9, 2014 is $15.00.

6. The total MAR for the disputed services is $127.33. The insurance carrier paid $0.00. A reimbursement of $127.33 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $127.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $127.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	September 17, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.